Attachment A

**South Carolina Department of Disabilities and Special Needs**

**COMMUNITY RESIDENTIAL ADMISSION/DISCHARGE REPORT**

Person's Name: _____ SSN: _____

Residential Provider: _____ Service Coordination Provider: _____

**Type of Action (check one)**

_____ New Admission _____ Transfer _____ Discharge

**Action Restrictiveness (check one)**

_____ More _____ Less _____ Equal _____ N/A (Moving to/from non-DDSN residential setting)

**New Admission:** (only complete for those who are not currently receiving DDSN funded residential services)

Date Placed on Critical Needs Waiting List: _____ **OR**
Date Placed on Priority I Waiting List: _____**OR**
Is Living with Aging Caregiver: _____ YES

Date of Proposed Admission: _____ Date Residential Services Desired: _____

Proposed Residential Setting (Name): _____ Type of Residential Setting (e.g., CTH II): _____

Type of Residential Vacancy Being Filled: _____ Existing _____ New (no one previously served in this vacancy)

Proposed Funding Band: _____
(Include a justification in Rationale section if a Band different from the standard funding band* is requested)

*Standard funding bands for new admissions: ICF/MR, CRCF and CTH II = Band G; SLP II = Band C; SLP I = Band D; CTH I =Band E and Enhanced CTH I = Band F .

**Transfer** (only complete for those who are currently receiving DDSN funded residential services)

Date of Proposed Transfer: _____ Date Transfer Desired: _____

Proposed Residential Provider: _____ Proposed Residential Setting (Name): _____

Type of Residential Setting (e.g., SLP, CTH I, CTH II, ICF/MR) Proposed: _____

Current Residential Provider: _____ Current Residential Setting (Name): _____

Current Type of Residential Setting (e.g., SLP, CTH I, CTH II, ICF/MR): _____

Current Funding Band: _____ Proposed Funding Band: _____
(Include a justification in Rationale section if a Band different from the standard funding band assignment* is requested)

*Standards funding band assignments for transfers: From regional center or alternative placement to ICF/MR, CRCF and CTH II = Band H. For all other transfers: ICF/MR, CRCF and CTH II = Band G; SLP II = Band C; SLP I = Band D; CTH I =Band E and Enhanced CTH I = Band F .

**Discharge** (only to be completed for those who will no longer receive residential services from any DSN Board or Contracted Provider)

Residential Setting Discharged From (Name): _____

Date of Proposed Discharge: _____ Proposed Service Agency After Discharge: _____

Proposed Post-Discharge Service (e.g., no service, in-home services, Nursing Facility, Private CRCF, etc.):
_____

Proposed Post-Discharge Service Funding Source (e.g., HCB waiver, state-funded day supports, state plan Medicaid, etc.):
_____

**Rationale: E**xplain why the proposed admission/transfer/discharge is recommended – may attach Program Team meeting minutes – must attach documentation of HRC approval for More Restrictive actions – also must include justification for funding at a band higher than standard band assignment as noted above.)

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**DSN Board/Contracted Service Provider Certification**

I hereby certify that the information contained in this report is accurate.

_____ _____
Executive Director Date

**SCDDSN Approval**

_____ _____ Date Residential Waiver Slot Awarded: _____
Assistant District Director Date

_____ _____ Date LOC Approved: _____
District Director Date

_____ _____ Date Medicaid Financial Eligibility Approved: _____
Director of Cost Analysis Date

**Send to the Assistant District Director at the DDSN District Office**